STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING 01 B. WING	04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/16/12 Facility Number: 000212 Provider Number: 155319 AIM Number: 100285040 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Clinton Gardens was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies. The was determined to be of Type V (111) construction and was fully	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review of paper compliance on or after May 16, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 113 and had a census of 85 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/23/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure corridor doors were free from impediments to closing in 1 of 7 smoke compartments. This deficient practice affects the visitors, staff and 20 or more residents using the main dining room. Findings Include: Based on observation with the maintenance director on 04/16/12 at 2:30 p.m., the self closing double door set separating the corridor from the main dining room failed to close and latch into the door frame when tested with the maintenance director. The	K0018	It is the intent of the facility to ensure corridor doors are free from impediments when closing.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*The self-closing double doors from the main dining room will be removed as part of the current renovation of the facility.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*All residents have the potential to be affected.*There were no other areas identified.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*The Maintenance Director will ensure the self-closing doors are	05/16/2012

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	doors were twice released from magnets holding the doors open and allowed to close. They failed each time when one door hit the other and prevented both from latching into the door frame. The maintenance director said at the time of observation, the doors were always a problem. 3.1-19(b)		removed.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*To ensure compliance, the Maintenance Director is responsible to ensure the dining room is compliant to Life Safety Standards prior to the doors being removed. The results of the removal will be reviewed by the CQI Committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance.	

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 3 of 10 doors to hazardous areas such as a kitchen were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors, staff and 20 or more residents using the dining room. Findings include: a. Based on observation with the maintenance director on 04/16/12 at 2:15 p.m., the self closing door to the dish room between the dining room and kitchen was prevented from	K0021	It is the intent of the facility to ensure doors to hazardous areas such as a kitchen are held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of a fire alarm system, local smoke detectors or an automatic sprinkler system. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *The trash receptacle was immediately removed. *An inservice was held with all dietary staff, 04/27/12 and 04/28/12, by the Certified Dietary Manager to educate regarding the importance of not impeding doors by placing receptacles, and the like, to prevent them from closing upon activation of a fire alarm system. *The self-closing double doors to the	05/16/2012

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	closing when a trash receptacle was left in the path of the door's swing leaving it open eight inches. The maintenance director said at the time of observation, the door would have been closed if staff had not left the receptacle there. b. Based on observation with the maintenance director on 04/16/12 at 2:15 p.m., the self closing double doors to the service opening between the dining room and kitchen were prevented from closing when one door hit the astragal of the first door to close and left a half inch gap. The maintenance director said at the time of observation, the doors would have closed if the second door had closed first. 3.1-19		service opening between the dining room and kitchen will be adjusted to properly close. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? *All residents have the potential to be affected. *An inservice was held with all dietary staff, 04/27/12 and 04/28/12, by the CDM to educate regarding the importance of not impeding doors by placing receptacles and the like to prevent them from closing upon activation of a fire alarm system.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? *The CDM shall perform audits/facility rounds daily to monitor that the doors are not impeded by receptacles and the like. *Staff found not to respond promptly and/or not continue to follow compliance will be immediately addressed. *The Maintenance Director will monitor the self-closing doors as a part of routine Preventative Maintenance rounds. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *To ensure compliance, the CDM is	

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			responsible for the completion Routine Compliance Rounds CQI tool weekly to ensure doors are not held open by items other than the closure, times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. *To ensure compliance, the Maintenance Director will complete Preventative Maintenance Rounds CQI tool weekly to monitor proper closure of the self-closing double doors to the service opening between the dining room and kitchen, times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. the results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed.	

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K0051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include:	K0051	It is the intent of the facility to maintain fire alarm systems in accordance with NFPA 72, 1999 edition. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*The circuit in the fire alarm system circuit breaker listed on the directory inside the emergency power circuit breaker box was clearly identified and marked with red marking and identified as FIRE ALARM CIRCUIT CONTROL. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*All residents	04/16/2012

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	Based on observation with the maintenance director on 04/16/12 at 3:20 p.m., the fire alarm system circuit breaker was listed on a directory inside the emergency power circuit breaker box, however, it was unclear which circuit was actually connected to the fire alarm control panel. The maintenance director said at the time of observation, he knew the fire alarm circuit breaker was connected to generator emergency power but he was unable to identify which circuit breaker it was. 3.1-19(b)		have the potential to be affected.*There were no others identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*The Mainenance Director will visually monitor all fire alarm circuit breakers listed on the directory inside the emergency power circuit breaker boxes as clearly identified and marked with red marking and identified as FIRE ALARM CIRCUIT CONTROL during routine Preventative Maintenance rounds.*Circuit breakers found not to have proper legible identification will be immediately marked. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*To ensure compliance, the Maintenance Director will complete Preventative Maintenance Rounds CQI tool, times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.	

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/16/12 Facility Number: 000212 Provider Number: 155319 AIM Number: 100285040 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Clinton Gardens was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The 2005 addition of 14 rooms on E wing was surveyed with Chapter 18, New Health Care Facilities. At the time of this survey, B wing was unoccupied due to construction.	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review of paper compliance on or after May 16, 2012.	

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	The 2005 addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 113 and had a census of 73 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include: Based on observation with the	K0051	It is the intent of the facility to maintain fire alarm systems in accordance with NFPA 72, 1999 edition.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*The circuit in the fire alarm system circuit breaker listed on the directory inside the emergency power circuit breaker box was clearly identified and marked with red marking and identified as FIRE ALARM CIRCUIT CONTROL. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*All residents have the potential to be affected.*There were no others identified. What measures will be	04/16/2012

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	maintenance director on 04/16/12 at 3:20 p.m., the fire alarm system circuit breaker was listed on a directory inside the emergency power circuit breaker box, however, it was unclear which circuit was actually connected to the fire alarm control panel. The maintenance director said at the time of observation, he knew the fire alarm circuit breaker was connected to generator emergency power but he was unable to identify which circuit breaker it was. 3.1-19(b)		put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*The Mainenance Director will visually monitor all fire alarm circuit breakers listed on the directory inside the emergency power circuit breaker boxes as clearly identified and marked with red marking and identified as FIRE ALARM CIRCUIT CONTROL during routine Preventative Maintenance rounds.*Circuit breakers found not to have proper legible identification will be immediately marked. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*To ensure compliance, the Maintenance Director will complete Preventative Maintenance Rounds CQI tool, times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.	

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K0147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure an attic electrical junction box observed above 1 of 7 smoke compartments was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 5 residents in the B/E hall lounge. Findings include: Based on observation with the maintenance director on 04/16/12 at 1:55 p.m., a junction box in the attic above the smoke barrier above rooms 18 and 19 was left uncovered. The maintenance director said at the time of observation, the attic fan	K0147	It is the intent of the facility to ensure attic electrical junction boxes are maintained in a safe operating condition. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *The junction box in the attic above the smoke barrier above rooms 18 and 19 was properly covered for compliance.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*All residents have the potential to be affected.*There were no other areas identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*The Maintenance Director will visually monitor all attic junction boxes to ensure they are properly covered for compliance as a part of routine Preventative Maintenance rounds quarterly or as needed when maintenance is performed in the attic. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *To ensure compliance, the Maintenance	04/27/2012

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	connected to the junction box was not in use but he acknowledged the wires were still "live." 3.1-19(b)		Director will complete Preventative Maintenance Rounds CQI tool, times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.	